Testimony of Congressman Patrick J. Kennedy
Committee on Government Reform
Subcommittee on the Federal Workforce and Agency Organization
"Is There a Doctor in the Mouse? Using Information Technology to Improve Healthcare"
2154 Rayburn House Office Building
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Mr. Chairman, Congressman Davis, thank you for inviting me to testify today. It's an honor to be with you and with my partner in crime, Tim Murphy.

The subject you are exploring today is, I think it can be said without hyperbole, critical to our country's long-term economic competitiveness, not to mention to hundreds of thousands of Americans who will be needlessly killed and seriously injured if we do not act.

We politicians love to say that we have the best health care system in the world. We generally do this while we're helping break ground for a new cardiac care facility or speaking to an audience of doctors.

And we're half right. We undoubtedly have some of the best health care in the world. Our practitioners are superb. Our medical technology is unsurpassed. Our facilities are state-of-the-art. But the system in which they exist fails.

You probably are aware that if an airliner crashed today and tomorrow and every day this week, it would approximate the number of our constituents who are losing their lives to preventable medical errors. Double that number to include all of the people who die as a result of hospital-acquired infections that are largely preventable but rarely prevented.

The costs of these system failures are borne not only by those directly affected; they impact us all. We all know what is happening with health care costs and the burden they are putting on families and businesses. We all know about the scourge of the uninsured and how that problem is growing.

Our system just is not set up to get the best care to people as efficiently as possible. So nearly half the time, according to a RAND study, patients fail to receive recommended care. We have some regions of the country spending 60% more than others on an adjusted basis, yet getting worse patient outcomes and satisfaction. Faxing, copying, filing, coding, and moving paper and other administrative costs eat up thirty cents of each health care dollar. Probably any person in this room can tell a story of duplication in the system, whether it's filling out that clipboard for the fifth time or repeating a battery of tests because this doctor doesn't have the results handy.

Information technology is emphatically not the panacea that will automatically solve these problems. But it's also hard to imagine these problems being solved without IT. In a digital health care system, providers can have the information they need right at the point of care. Computer algorithms can catch mistakes and prompt to ensure consideration of latest scientific developments. Public health officials can be alerted nearly immediately of unusual patterns that

might indicate a natural or bioterror infectious outbreak, or to catch the next Vioxx before tens of thousands are put at risk. Researchers would have vast new databases to learn more about what works.

The vision is compelling, but of course getting from here to there is no easy task. I see four key components to achieving this vision:

First, privacy and security are absolutely paramount. People will pass up the enormous benefits that IT could provide to them individually and to society if they believe their health privacy may be compromised. Theoretically, I am convinced that digital health care can be made more secure that paper, which is difficult to secure and nearly impossible to monitor access to. But we need to ensure that the technical solutions are ready for prime time and that the regulatory structures are in place to ensure rigorous adherence to the privacy and security requirements.

Second, we need to get technology into providers' and consumers' hands. There have been all sorts of analyses of the obstacles to IT adoption, but certainly high on the list are the costs, not only of the hardware and software, but of the process of integrating these systems into practice. These costs are, by all estimates, recouped many times over, but not necessarily by the people who incur them. The cost-benefit mismatch, where employers and plans realize many of the gains of provider investments, is a key dynamic that we need to address.

Third, we need to create the interoperable networks that allow information to be shared seamlessly among physicians, individuals, public health agencies and other authorized users. Under David Brailer's leadership, we have taken important steps towards creating the predicates of interoperable health information networks. We need to continue this work towards standards while also beginning to invest in the infrastructure that will allow information to flow. Who will create and maintain these networks, what data will flow into and through them, who will own that data, how will it be financially sustained, how will access be governed? There are many questions and, I'm sure, many possible answers. We need to support the development of models that are flexible and innovative but uniform enough to ensure interoperability.

Finally, we need to be building this information infrastructure with an eye towards the real goals of improving quality, safety, and efficiency. The promise of health IT is in what the new data can allow us to do. If we simply do what we've been doing a little bit faster, we do not address the coming health care crisis. We need to use the data to help us deliver the right care to the right people at the right time as efficiently as possible by learning what works best and by improving the use of that knowledge.

The bill Congressman Murphy and I wrote, the 21st Century Health Information Act, attempts to address all of these tasks. We believe that Congress needs to pass legislation that begins to change the systemic dynamics that have hindered the development of the digital health care system. It's not just about plowing federal dollars into IT systems, it's about strategically using our resources to start the ball rolling, and then making sure the federal government doesn't get in the way. We believe that a coordinated regional approach is the best way to simultaneously drive both adoption and development of networks, provided that it's done within a framework of national standards and criteria. Our bill leverages the private sector involvement and leadership

this task requires and offers systemic solutions to systemic problems on a pilot basis. It respects the learning we need to do but is scalable.

I would be happy to discuss at greater length with any of the committee members my thoughts about what our legislative priorities should be. We introduced our bill to begin that conversation and are pleased that the discussion has taken off. There are a number of other bills, including the very strong Senate bill reported out of the HELP Committee last week, which add important improvements.

But given your jurisdiction, I'd like also to say a few words specifically about the Federal Employees Health Benefits Program, and how I think it can be a force for driving improvements in our health care system.

I have been speaking to business audiences in Rhode Island and around the country trying convince them that they are not getting their money's worth for their health care dollar and that we need their leadership. I would make the same argument to you as the committee overseeing federal employee health spending. Employers, including the FEHBP, need to invest in improving the value of the health care system.

There are numerous creative ways that FEHBP could help drive the digital revolution and spur higher quality and efficiency. I'm sure these conversations are going on within OPM. But I would offer a few concrete suggestions:

- The FEHBP should provide a personal health record to every beneficiary. These records are owned by the individual and contain key data. They can make that clipboard obsolete and ensure that emergency room physicians aren't trying to figure out somebody's status by digging through a paper bag full of the contents of a medicine cabinet. They can provide a structured way for patients to get meaningful reminders pertinent to their particular needs, like prescription refill reminders or patient education materials.

- If you wanted to go one step further, the FEHBP could pilot a personal health record fed by claims data. Much of a person's relevant health information is included in claims data, such as which prescriptions they have filled. This information could automatically feed a personal health record to increase its value and accuracy.

- I also believe that FEHBP should lead other employers by example by participating in regional efforts to spur provider adoption and develop information sharing networks. Particularly in the Washington area, where there is such a high concentration of federal employees, it makes good sense for the FEHBP to financially and morally support these efforts. Ultimately, those who pay the health care bills are going to have to help capitalize these IT efforts. FEHBP could do that in many ways, for example by encouraging plans to bump up reimbursement rates for providers who meet certain criteria for IT use in the provision of care.

- Finally, I would urge FEHBP to reinforce CMS's efforts by adopting the same goals and performance metrics so that we start learning which providers are doing the best job.

This step would not only begin explicitly making providers accountable for quality, but would help drive IT adoption because data reporting is difficult without technology.

We are standing on the edge of a monumental change in health care. We have come far in so short a time. I applaud the subcommittee's pursuit of this important topic and look forward to working with you to make our health care system truly the best in the world.

Thank you.

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